PRE-OPERATION VISIT
FOR
FAMILY DAY CARE HOMES

1. Provider Name _____
   Address _____
   _____
   County_____ Phone_____

2. Provider's own children:

Full Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

3. Is the provider claiming his/her own children? □ Yes □ No
4. Is the provider claiming related children over capacity? □ Yes □ No
   If Yes, list children's names and relationship to the provider

Child's Name	Relationship to the Provider

5. Type of provider: ☐ Registered ☐ Certified ☐ Licensed
6. License capacity: _____ Expiration Date ___/___/___
7. Have record keeping requirements been explained to and discussed with the provider?
   ☐ Yes ☐ No
8. Is the provider willing to and capable of maintaining the required daily CACFP records?
   ☐ Yes ☐ No
9. Is kitchen equipment suitable for food service?
   ☐ Yes ☐ No
10. Is kitchen clean and well organized?
    ☐ Yes ☐ No
11. Is dining area suitable for children?
    ☐ Yes ☐ No
12. Are thermometers available for both refrigerator and freezer?
    ☐ Yes ☐ No
13. Does the provider wish to participate in the Child Care Food Program?
    ☐ Yes ☐ No
15. Describe plan for correcting deficiencies identified in this visit:
    _____
    _____
16. Has the provider ever been terminated or determined "seriously deficient" by another sponsoring organization?
    ☐ Yes ☐ No

_____ _____

Signature of Sponsor Representative Date Signature of Provider Date